RESIDENTIAL TREATMENT COST REPORT -DUE DATE- JAN 31, 2006

N C DEPARTMENT OF HEALTH AND HUMAN SERVICES - DIVISION OF MEDICAL ASSISTANCE

RESIDENTIAL TREATMENT COST REPORT - 2006 **SCHEDULE A**

Part I - General

Reporting Basis **[ ] Cash** **[ ] Accrual**

1. Tax ID#

Facility Name:

Street or P.O.:

City:

State: Zip:

2. Mailing Address (***If different from above)***

Street or P.O.:

City, State, Zip:

3. Name of Contact/ Director/Administrator:

4. Telephone No.

5. Email Address:

6. Fax Number :

7. Medicaid Provider #:

8. Fiscal Year Ending (per Audit):

9. # of Months in Operation: (see instructions):

From: To:

10. Previous Owner Medicaid #:

11. Licensed Bed Capacity by Level of Care:

Level 1 **Level II** **Level III**

Level IV **PRTF** **Other**

12. Total number of Multiple Facilities:

Part II - Tax Information

13. Tax Status:
[ ] 1. Government
[ ] 2. Private

a. Voluntary Non-Profit
[ ] 1. Church
[ ] 2. Other (Specify):

b. Proprietary
[ ] 3. Sole proprietorship
[ ] 4. Corporation
[ ] 5. Partnership
[ ] 6. Other

Part III - Resident Days

14. Total No. of Non-Medicaid Resident Census Days:

15. Total **LICENSED** Bed Days Available for Non-Treatment Resident Care:

15a. Total **AVAILABLE** Bed Days for Non-Treatment Resident Care:

16. Total No. of Treatment Days:

Level I **Level II** **Level III** **Level IV** **PRTF** **Other**

17. Total **LICENSED** Bed Days Available for Treatment:

Level I **Level II** **Level III**

Level IV **PRTF** **Other**

17a. Total **AVAILABLE** Bed Days for Treatment:

Level I **Level II**

Level IV **PRTF**

Part IV - Certification of Accuracy

The undersigned individual (company) does hereby state that the report forms (Schedule A, B, C, C-1, D) have been prepared from accounting records of the agency/facility and are accurate based on recorded information and/or information provided.

Chief Executive/Agency Official's Signature Date:

Auditor's Signature Date:

Auditor's Telephone Number:

Preparer's Signature Date:

Preparer's Telephone Number: